No. 83-2136

IN THE SUPREME COURT
OF THE UNITED STATES

OCTOBER TERM, 1984

STATE OF CONNECTICUT, DEPARTMENT
OF INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, Secretary
and the UNITED STATES
DEPARTMENT OF HEALTH AND
HUMAN SERVICES,

Respondents.

On Writ of
Certiorari To The United
States Court of Appeals
For the Second Circuit

BRIEF OF AMICUS CURIAE
Commonwealth of Massachusetts

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TABLE OF CONTENTS

	Page
INTEREST OF AMICUS CURIAE	1
SUMMARY OF ARGUMENT	6
ARGUMENT	
I. THE SECRETARY'S DISALLOWANCE POWER DOES NOT INCLUDE THE POWER RETROACTIVELY TO ALTER CONDITIONS ON FEDERAL GRANTS.	11
A. Introduction	11
B. Conditions on Medicaid Reimbursement Must Be Clearly And Seasonably Stated.	15
C. Retrospective Disallowances on Substantive Grounds Contradict the Language and Spirit of Title XIX and Decisions of this Court.	19
D. Rectifying the Balance Between State and Federal Authority Under Title XIX Will Not Undermine the Secretary's Role.	29
II. THE SECOND CIRCUIT ERRED IN ADOPTING THE SECRETARY'S INTERPRETATION OF THE STATUTE.	32

Page

A. The Interpretive Bases for the Secretary's Retrospective Disallowances Are Not Entitled To Judicial Deference. 32

B. The Secretary's Attempts to Redefine Nursing Homes As Institutions For Mental Diseases Thwart Congressional Policies Toward Care of the Mentally Ill and Improperly Punish States that Have Implemented These Policies. 37

1. The Secretary's Position Defies Congressional Intent To Encourage the Development And Utilization of Alternatives To Mental Hospitals In Caring For the Mentally Ill. 38

2. The Secretary's Action Improperly Punishes States That Responded To Congressional Directives By Developing and Utilizing Alternatives to Mental Hospitals in Caring for the Mentally Ill. 52

CONCLUSION

TABLE OF AUTHORITIES

Page

CASES

American Shipbuilding Co. v. Labor Bd., 380 U.S. 300 (1965) 36

Batterton v. Francis, 432 U.S. 416 (1977) 35, 37

Bell v. New Jersey, 103 S. Ct. 2187 (1983) 15n, 29

Chevron v. Natural Resources Defense Council, 81 L. Ed. 2d 694 (1984) 35

Harris v. McRae, 448 U.S. 297 (1980) 17, 31

Hendrick Hudson Dist. Bd. of Ed. v. Rowley, 458 U.S. 176 (1982) 15

Labor Bd. v. Brown, 380 U.S. 278 (1965) 36

Medical Services Admin. v. U.S., 590 F. 2d 135 (5th Cir. 1979) 20n

Pennhurst State Hospital v. Halderman, 451 U.S. 1 (1978) passim

Schweiker v. Gray Panthers, 453 U.S. 34 (1981) 34

	Page
Schweiker v. Wilson, 450 U.S. 221 (1981)	46
State of Conn. v. Heckler, 731 F. 2d 1053 (2d Cir. 1984)	12, 33n
State of Florida v. Mathews, 526 F. 2d 319 (5th Cir. 1976)	34
State of Minn. by Noot v. Heckler, 718 F. 2d 852 (8th Cir. 1983)	33n 37, 41n, 47n, 50
State of New Jersey v. Department of HHS, 670 F. 2d 1262 (3d Cir. 1981)	20n
U.S. v. Cartwright, 411 U.S. 546 (1973)	36
U.S. v. Vogel Fertilizer Co., 455 U.S. 16 (1982)	35, 36

CONSTITUTIONAL PROVISIONS

United States Constitution Article I, § 8, cl. 1	13, 16

STATUTES

42 U.S.C. § 242(b)	43
42 U.S.C. § 1302	34

	Page
42 U.S.C. § 1316(d)	21
42 U.S.C. § 1395x(k)	49
42 U.S.C. § 1396	45
42 U.S.C. § 1396a	25
42 U.S.C. § 1396a(a)(17)(B)	35
42 U.S.C. § 1396a(a)(20)	45, 47
42 U.S.C. § 1396a(a)(21)	47
42 U.S.C. § 1396a(a)(30)	49
42 U.S.C. § 1396a(a)(31)	49, 50
42 U.S.C. § 1396a(b)	30
42 U.S.C. § 1396b(a)	18, 22, 23, 24, 28, 30
42 U.S.C. § 1396b(d)(1)	26
42 U.S.C. § 1396b(d)(2)	27, 28
42 U.S.C. § 1396b(i)(4)	49
42 U.S.C. § 1396c	21, 26, 30
42 U.S.C. § 1396d(a)(1)	45
42 U.S.C. § 1396d(a)(4)(A	40n
42 U.S.C. § 1396d(a)(14)	8, 11

	Page
42 U.S.C. § 1396d(a)(15)	40n, 47
42 U.S.C. § 1396d(a)(18)(B)	8, 11, 47
42 U.S.C. § 1396d(c)	39n
42 U.S.C. § 1396d(c)(1)	48
42 U.S.C. § 1396d(f)	39n
42 U.S.C. § 2689 (repealed, 1981)	44, 45
Mass. Gen. Laws. Ann. ch. 19	53

REGULATIONS

42 C.F.R. § 405.1121(1)1	50
42 C.F.R. § 435.1009(e)(2)	32
42 C.F.R. § 441.106	47n
42 C.F.R. § 442.306	50
42 C.F.R. § 456	50

LEGISLATIVE HISTORY

H.R. Rep. No. 694, 88th Cong., 1st Sess. 11, reprinted in [1963] U.S. Code Cong. and Ad. News 1054	46n

	Page
S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in [1965] U.S. Code Cong. and Ad. News. 1943	46n, 47n
117 Cong. Rec. 44721 (1971)	48n

MISCELLANEOUS

2 R. Cappalli, Federal Grants and Cooperative Arrangements, §§ 8.13-8.16 (1982)	27
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J. Gudeman and M. Store, Beyond Deinstitutionalization, 311 New Eng. J. of Med. 832 (1984)	53n, 54n, 55n
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Page

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INTEREST OF AMICUS CURIAE

The Commonwealth of Massachusetts (the "Commonwealth") submits this brief amicus curiae in support of the position of the petitioner State of Connecticut.

The interests of the amicus relevant to the case are both legal and financial. The Commonwealth's legal interest encompasses the proper construction of the statutes which govern Medicaid reimbursement for services provided persons in institutions for mental diseases ("IMD"). The Commonwealth has recently appealed the Secretary's disallowance of $1,142,092 in reimbursement for such services. (United States District Court for the District of Massachusetts. C.A. No. 83-2239-Mc). In that case, the Secretary has invoked substantially the same legal grounds for her disallowance as asserted in the Connecticut case. Accordingly, on the primary question of statutory construction posed by this case, the Commonwealth endorses the position of the petitioner State of

Connecticut.

On a more general level, as a party to the Medicaid contract with the Secretary, the Commonwealth has a profound interest in the related question: what are the parameters of the agreement between the United States and the States, and under what standards may the Secretary retrospectively disallow expenditures made in accordance with an approved state plan? This broad inquiry subsumes questions of whether, and to what degree, judicial deference is properly accorded the Secretary's retrospective interpretations of statutes and regulations under the Medicaid program.

The interests of the Commonwealth are financial as well. In addition to its District Court challenge to the IMD

disallowance, the Commonwealth also currently contests, in administrative and judicial forums, approximately eleven million dollars in disallowed reimbursement for services provided persons in intermediate care facilities for the mentally retarded. Several million are also at stake in a dispute concerning the reimbursement of "over-payments" to nursing homes. These costs, while significant, reflect only the previous targets of the Secretary; millions of dollars for other services may also fall under her aim. As a state which would bear the fiscal burdens imposed by (1) an adverse construction of the statute governing Medicaid reimbursement for services in institutions for mental diseases, and (2) an expansive

interpretation of the Secretary's power of retrospective disallowance, the Commonwealth of Massachusetts is well qualified to convey these concerns to the Court.

Finally, the Commonwealth asserts a policy interest in the consequences of the adoption of the Secretary's legal argument. Massachusetts currently provides treatment to many of its the mentally ill in its ICFs. The Commonwealth has a profound interest in maintaining Medicaid reimbursement for services in less intensive and expensive settings. To the extent that the Secretary's position would discourage treatment of the mentally ill in such settings, her argument would adversely affect important State programs.

SUMMARY OF ARGUMENT

I. This case poses an important and recurring issue at the heart of the Medicaid program: what is the nature and extent of the power of the Secretary to retrospectively disallow expenditures made by States in accordance with their approved state Medicaid plans?

As a general proposition, the Court has required Congress to seasonably and unambiguously express federal conditions on the States' receipt of grants under the Medicaid program. The Secretary's assertion of unilateral power retrospectively to interpret Title XIX and to disallow reimbursement on the basis of such post hoc interpretations offends this constitutional requirement.

Furthermore, Title XIX imposes only two conditions on federal reimbursement: first, the State must have an approved plan; and second, State expenditures must have been made under the plan. The power asserted by the Secretary to disallow federal reimbursement for expenditures on the basis of a retrospective interpretation of ambiguous statutory terms makes the federal bargain with the states illusory. Where the states incur expenditures in reliance upon the Secretary's approval of their plans, and where there is no countervailing congressional directive, the Secretary should be compelled to honor the federal promise of reimbursement.

II. On the central statutory question presented by this case, the

amicus endorses Connecticut's interpretation of the IMD exclusion. At the threshold, we demonstrate why the Secretary's construction of 42 U.S.C. §§ 1396d(a)(14) and (18)(B) should be given, at most, interpretive rather than legislative effect. Since Title XIX lacks any provision expressly delegating substantive rulemaking power to the Secretary to define IMDs, little, if any, judicial deference should be accorded the Secretary's statutory construction.

The proper construction of the IMD exclusion is best understood against the backdrop of the broader problem of the treatment of the mentally ill. The services provided the mentally ill by Massachusetts and other states in their

ICFs were not developed in a legislative vacuum. To the contrary, services outside traditional mental institutions were encouraged by Congress through Medicaid and other acts. Federal support for alternative services focused on the nature and degree of care required by the patient. The Secretary's definition of the term IMD ignores these efforts and focuses on the number of patients who are former or potential mental hospital patients. The restricted reimbursement which results frustrates the system promoted by Congress to ensure appropriate treatment of the mentally ill.

Finally, the Secretary's disallowance punishes states such as Massachusetts, that have committed substantial

efforts and resources to the development of alternatives to treatment in mental hospitals. State and national statistics demonstrate a significant trend toward deinstitutionalization, and a concomitant increase in the number of ICFs.

The available evidence thus shows that the States responded to congressional encouragement of alternative treatment. The Secretary's retrospective interpretation of the IMD exclusion effectively punishes the States for pursuing this course. The adoption of the Secretary's argument would seriously undermine future state efforts in the treatment of the mentally ill.

ARGUMENT

I. THE SECRETARY'S DISALLOWANCE POWER DOES NOT INCLUDE THE POWER RETROACTIVELY TO ALTER CONDITIONS ON FEDERAL GRANTS.

A. Introduction

The significance of this case transcends the financial consequences of the Secretary's expansive construction of the term "institution for mental diseases" found in 42 U.S.C. § 1396d(a)(14) and (18)(B). The case also poses another issue, one at the heart of the Medicaid program: in what circumstances are the States entitled to rely on the federal reimbursement promised by Congress in exchange for their participation in the Medicaid program? The Secretary has taken the position in many recent disallowance cases that the States are

entitled to partial reimbursement for their expenditures only if, in the Secretary's considerable discretion, she determines after the fact that those expenditures were lawful. This position is quite clearly asserted in the Brief for Respondents in Opposition to the Petition, at 8-9.

The Second Circuit in this case adopted this tilted view of the relationship between the Secretary and the States under the Medicaid program. The court concluded that "the IMD definition adopted by HHS and supplemented by its internal criteria reasonably implements Congress' intent." State of Connecticut v. Heckler, 731 F. 2d 1053, 1060 (2d Cir. 1984). In so ruling the court

treated the Medicaid program as an essentially regulatory program in which the views of the administering agency drive judicial interpretation of applicable statutes and regulations. However, Title XIX is an exercise of the spending power, not an assertion of federal regulatory control over the states. The relationship between the states and the federal government is essentially contractual in nature, and the terms of that relationship -- the conditions upon which the states receive federal grant money -- must be seasonably and unambiguously stated. Whatever the Secretary's regulatory powers may be under Title XIX, they do not include the power to alter -- or "interpret" -- the terms

of the federal agreement retrospectively in a disallowance proceeding. Such would amount to the power to "surpris[e] participating States with post-acceptance or 'retroactive' conditions," which is forbidden even to Congress. Pennhurst State School & Hospital v. Halderman, 451 U.S. 1, 25 (1978). Further, our analysis of the statutory terms of Title XIX will show that Congress did not attempt to confer any such power on the Secretary. Rather, Title XIX requires the Secretary to pay the federal share of all of the states' expenditures under an approved state plan, subject only to explicit statutory exceptions and the Secretary's lawful prospective interpretations.

B. Conditions on Medicaid Reimbursement Must Be Clearly And Seasonably Stated.

Since the decision of the Second Circuit will, if upheld, significantly increase the financial obligations of the Commonwealth and other states, the statutory language must be judged by the principle of statutory construction that "Congress must express clearly its intent to impose conditions on the grant of federal funds so that the States can knowingly decide whether or not to accept those funds." Pennhurst State School v. Halderman, 451 U.S. at 24. See Hendrick Hudson Dist. Bd. of Ed. v. Rowley, 458 U.S. 176, 204 n. 26 (1982).[1/] Legislation such as the Medicaid statute,

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1/ Unlike the situation in Bell v. New Jersey, 103 S. Ct. 2187 (1983), this

(footnote continued)

enacted pursuant to the spending power, is "in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions." Pennhurst, 451 U.S. at 17. Congress' power to legislate under the spending power rests on the States' "knowing acceptance" of the conditions of the "contract." Ibid. Conditions on the grant of federal monies must therefore be timely and "unambiguous." Ibid.

(footnote continued)

case turns on the question whether the disallowed sums were expended under the state plan. In the amicus' view, the Secretary's attempt in this and other cases to disallow federal financial participation on the basis of a post hoc (or undisclosed) interpretation of a vague statutory term (and equally vague regulation) amounts to the retroactive imposition of a new condition on the federal grant. See id. at 2197 n. 17; id. at 2199 (White, J., concurring).

The nature and purpose of the Medicaid program underscore the constitutional requirement of a clear and seasonable statement of contractual conditions. "The Medicaid program created by Title XIX is a cooperative endeavor in which the Federal Government provides financial assistance to participating states to aid them in furnishing health care to needy persons." Harris v. McRae, 448 U.S. 297, 308 (1980). The program is one of "cooperative federalism," in which the Federal Government agrees to pay a specified percentage of the total amount expended under the Medicaid plan submitted by the State and approved by the Secretary. Id. The purpose of Congress in enacting Title XIX was "to

provide Federal financial assistance for all legitimate state expenditures under an approved Medicaid plan." Id. (citation omitted). The Act expressly provides that the Federal Government will share the cost of a state's medical assistance program to the extent that the cost is incurred under a plan approved by the Secretary. 42 U.S.C. § 1396b(a).

For these reasons, the Court has indicated that such exercises of the spending power as that exemplified by the Medicaid program are governed by the rule that conditions imposed on the States must be seasonably and unambiguously expressed. Pennhurst v. Halderman, 451 U.S. at 22. We demonstrate below

that the Secretary's process of disallowance, which is based solely upon a retrospective interpretation of ambiguous statutory or regulatory terms, violates these limitations and contradicts the purpose and terms of Title XIX.

C. Retrospective Disallowances on Substantive Grounds Contradict the Language and Spirit of Title XIX and Decisions of this Court.

Since the "clear statement" rule recognized in Pennhurst governs the Medicaid program generally, id. at 22, the question becomes whether the process of audit, interpretation, and disallowance followed by the Secretary in this and similar cases comports with that rule and the purposes of Title XIX. If the Secretary's process is proper and her

power of disallowance clear, there remains the question whether the interpretive bases for the Secretary's retrospective disallowances are entitled to deference by reviewing courts.[2/]

The authority to sanction a State for noncompliance, or to disallow claims, must be unambiguously noted in some provision of law applicable to the grant program under which the action is taken.

2/ We assume here that the Secretary's power of disallowance extends beyond mechanical or routine calculations, or the routine classification of claims for the purpose of determining the assistance percentage. That power is not free from doubt, however. See, e.g., State of New Jersey v. Department of HHS, 670 F. 2d 1262, 1274-75 (3d Cir. 1981); Medical Services Admin. v. United States, 590 F. 2d 135, 136 (5th Cir. 1979) (disallowance disputes usually turn on accuracy of audit).

Pennhurst, 451 U.S. at 17. The compliance procedure under 42 U.S.C. § 1396c specifically sets forth the grounds for federal action and limits relief to prospective withholding of payments. In contrast, the disallowance procedure is neither defined nor specifically authorized in the text of Title XIX. Section 1316(d) of 42 U.S.C. does not define the term, but provides as follows:

> (d) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under Title I, VI, X, XIV, XVI, or XIX, or part A of subchapter IV of this chapter, shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

42 U.S.C. § 1316(d). Section 1316 appears in Title XI of the Social

Security Act, which contains general provisions applicable to many grant programs within the Act. The section itself was enacted with the caption "Administrative and Judicial Review of Certain Administrative Determinations." It does not explicitly empower the Secretary to disallow claims for federal financial participation for items of expense under any grant program. In the absence of such enabling language, authority for the disallowance procedure must be found in the provisions of Title XIX.

The starting (and ending) point in the search for conditions imposed on grants under Title XIX, and, hence, in the search for disallowance authority, is 42 U.S.C. § 1396b. Subsection (a) of

that section provides that

> the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter . . .
>
> (1) an amount equal to the Federal medical assistance percentage . . . of the total amount expended during such quarter as medical assistance under the State plan . . . .

The remaining subsections, except subsection (d), set forth exceptions to this general rule. In short, Title XIX imposes exactly two general conditions upon federal financial participation in a State's medical assistance expenditures. First, the State must have an approved plan; second, the State's expenditures must have been made under the State plan. Notably absent is any provision permitting disallowance of items of expendi-

ture under the State plan; if the expenditure is made under an approved plan, § 1396b(a) requires that it be reimbursed.[3/] The absence of additional conditions is not an oversight; rather, it reflects the contractual nature of the state and federal governments' mutual undertakings. Section 1396b(a) implicitly recognizes that if a state undertakes to operate a program or plan which, it is assured, meets federal criteria, it is entitled to rely on the federal government to bear that part of the burden which it has said it will bear. Congress did not reserve to the Secretary

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3/ We do not dispute the Secretary's power in general to disallow claims for assistance to ineligible recipients or uncertified providers. These would not be expenditures under the plan.

the right to reconsider her approval of a plan, in order to deny federal participation in expenditures already incurred by the State. Such a reservation would verge on a claim of right to "surpris[e] participating States with post-acceptance or 'retroactive' conditions." Pennhurst State School v. Halderman, 451 U.S. at 25.

It follows that a doubt on the Secretary's part as to whether an approved plan complies with § 1396a cannot form the basis of a disallowance. When the Secretary has second thoughts about the acceptability of a State plan, the course provided by law is to notify the State of her doubts, hold a hearing, and, if her doubts survive the hearing and

judicial review, to prospectively withhold payment. 42 U.S.C. § 1395c.[4/]

In a number of recent disallowance cases, the Secretary has identified § 1396b(d) as the wellspring of her power to disallow expenditures made in accordance with the state plan on the basis of after-the-fact interpretations of Title XIX or of her regulations. Under § 1396b(d)(1), the Secretary is required to "estimate the amount to which a state will be entitled under subsections (a)

4/ Thus, insofar as the Secretary is vested with regulatory authority, she may use that authority to alter or supplement program requirements prospectively. In this part, the amicus simply contests the Secretary's power to give her regulatory actions retrospective effect.

and (b) of this section" prior to the start of each quarter. Under § 1396b (d)(2), the Secretary is required to pay to the States "the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter . . . ." The Secretary does not merely claim that she may offset past overpayments against current payments under this section. Such would be a usual feature of a grant program. See, e.g., 2 R. Cappalli, Federal Grants and Cooperative Arrangements §§ 8.13-8.16 (1982). Rather, the Secretary claims that this language gives her power to

make a unilateral determination, to which reviewing courts must defer, and which is therefore binding on the states, that a particular expenditure is not reimbursable. However, while such a power may be a feature of regulatory programs, it is unusual to say the least in a con- tractual setting. Moreover, it is not consonant with the requirement of § 1396b(a) that the Secretary pay the federal share of state expenditures under an approved plan. Since it is not a required reading of § 1396b(d)(2); since it would be an unusual and harsh power in a contractual setting; and since it does not harmonize with the tenor of Title XIX as a whole, the Secretary's reading of this provision should be

rejected under the "clear statement" rule of Pennhurst, supra. See also Bell v. New Jersey, 103 S. Ct. 2187, 2199 (1983) (White, J. concurring).

D. Rectifying the Balance Between State and Federal Authority Under Title XIX Will Not Undermine the Secretary's Role.

The argument against the Secretary's asserted power to disallow federal participation on the basis of a post hoc interpretation of statutory conditions does not threaten Federal supervision of the Medicaid program. The Secretary's interest in the program is adequately protected without the power of substantive, retrospective disallowance.

At a general level, the Secretary retains authority to specify the

contents of state plans and approve or disapprove these plans. 42 U.S.C. §§ 1396, 1396a(b). The Secretary can enforce compliance with the plan through appropriate proceedings. 42 U.S.C. § 1396c. These exercises of authority place the states in the same or a greater position of risk than the Secretary.[5/]

The Secretary also benefits from the particular protection which resides with the congressional power of amendment. Section 1396b(a) provides that "the Secretary (except as otherwise provided

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5/ Of course the states, as financial partners in Medicaid, bear an equal financial risk, which in itself is a powerful stimulus to accurate adminstration.

in this section) shall pay . . . ." Congress may thus condition the prospective obligations of the Federal Government, provided that it does so seasonably and unambiguously. Congress has not, however, reserved to the Secretary the right to retrospectively disapprove state expenditures which were made properly, in accordance with the state plan; it has not empowered the Secretary to renege on the federal promise. See Harris v. McRae, 448 U.S. at 309 (1980). The nullification of the Secretary's asserted power of retrospective interpretation and disallowance, therefore, would do no more than restore to the federal-state relationship the balance intended by Congress.

II. THE SECOND CIRCUIT ERRED IN ADOPTING THE SECRETARY'S INTERPRETATION OF THE STATUTE.

A. The Interpretive Bases for the Secretary's Retrospective Disallowances Are Not Entitled To Judicial Deference.

In the preceding section, the amicus argued that the Secretary may not base a disallowance on a post hoc interpretation of an ambiguous statute or regulation. Such, it is submitted, is the Secretary's regulation defining the term "institution for mental diseases" as one "engaged in providing diagnosis, treatment or care of persons with mental diseases . . . ."[6/] 42 C.F.R. § 435.1009(e)(2).

6/ On its face, the regulation could refer to traditional mental hospitals, or to institutions primarily engaged in treating the mentally ill as such. See

(footnote continued)

If the Court nevertheless determines either that the post hoc interpretation of the regulation suffices or that the regulation is unambiguous, the question remains whether the Secretary's reading is consistent with federal law. This question subsumes two others: first, what if any deference should be given to the Secretary's regulation; second, is the regulation consistent with the statute it purports to interpret? The amicus turns to these questions.

The Social Security Act authorizes the Secretary to publish rules and

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(footnote continued)

Minnesota v. Heckler, 718 F. 2d 852, 862 (8th Cir. 1983). The Secretary's view draws its strength, not from the regulation, but from the intra-office memorandum specifying criteria to be used in assessing an institution. See Connecticut v. Heckler, 731 F. 2d at 1054.

regulations "not inconsistent with [the] Act, as may be necessary to the functions with which [she] is charged under [the] Act." 42 U.S.C. § 1302. E.g., State of Florida v. Mathews, 526 F.2d 319, 323 n. 9 (5th Cir. 1976). This general authority must be contrasted with the Secretary's exceptionally broad "authority to prescribe standards for applying certain sections of the [Social Security] Act," discussed in Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981) (emphasis supplied). There, the Court upheld the Secretary's regulations defining eligibility requirements under the Social Security Act because the Act explicitly delegated to her the substantive authority to determine eligibility standards. See

42 U.S.C. § 1396a(a)(17)(B).[7/]

In the absence of an express delegation of substantive rulemaking authority, the Secretary's promulgation of regulations under the Medicaid program should be given interpretive rather than legislative effect. See, e.g., Chevron v. National Resources Defense Council, 81 L. Ed. 2d 694, 703 (1984); Batterton v. Francis, 432 U.S. 416, 424-6 (1977); United States v. Vogel Fertilizer Co., 455 U.S. 16, 24-25 (1982). See generally 2 Davis, Administrative Law Treatise at 36-63 (2d ed. 1979). Furthermore, while

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7/ 42 U.S.C. § 1396a(a)(17)(B) provides that states must grant benefits to eligible persons, "taking into account only such income and resources as are available as determined in accordance with standards prescribed by the Secretary, to the applicant."

some deference is ordinarily owing to an agency's interpretation of its own regulation, this general principle "only sets 'the framework for judicial analysis; it does not displace it.'" Vogel, 455 U.S. at 24, quoting from United States v. Cartwright, 411 U.S. 546, 550 (1973). "The deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia which results in the unauthorized assumption by an agency of major policy decisions properly made by Congress." Labor Board v. Brown, 380 U.S. 278, 292 (1965), quoting from American Shipbuilding Co. v. Labor Board, 380 U.S. 300, 318 (1965).

Finally, where an agency's interpretation does not reflect an exercise of expressly delegated congressional

authority to prescribe substantive standards for determining the meaning of the statutory phrase, the question must be resolved by the court. See Batterton v. Francis, supra; State of Minn. by Noot v. Heckler, 718 F. 2d 852, 860, 865 (8th Cir. 1983).

As the amicus will next show, the Secretary's interpretation of the statutory terms governing reimbursement of services at IMD's undermines a key component of the States' Medicaid programs.

B. The Secretary's Attempts To Redefine Nursing Homes As Institutions For Mental Diseases Thwart Congressional Policies Toward Care of The Mentally Ill and Improperly Punish States That Have Implemented These Policies.

The amicus joins Connecticut in its exposition of the statute at issue here. In this part, the amicus will state its

own understanding of the congressional purpose, in light of the broad problem of the institutionalized mentally ill. The amicus believes that neither legislative meaning nor the implications of the Secretary's position can be adequately understood except in this broader context.

1. The Secretary's Position Defies Congressional Intent To Encourage the Development And Utilization of Alternatives To Mental Hospitals In Caring For The Mentally Ill.

The current attempts by the Secretary to redefine skilled nursing facilities (SNFs) and intermediate care facilities (ICFs)[8/] as institutions for mental

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8/ Skilled nursing facilities and intermediate care facilities are two types of nursing homes that differ according to the intensity of care provided.

(footnote continued)

diseases (IMDs) were prompted, in part, by the deinstitutionalization of the mentally ill that has occurred during the past twenty-five years. This movement, prompted in part by federal financial incentives, resulted in the release of thousands of mental hospital patients into the community. It also led to the development and utilization of alternative facilities, such as ICFs and SNFs, and other community-based services, to provide more appropriate care for these

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(footnote continued)

Compare 42 U.S.C. § 1396d(f) with 42 U.S.C. § 1396d(c). Although the case before the Court involves only ICFs, HHS intends to use the same criteria in determining whether SNFs are IMDs. Therefore, many of the arguments advanced in this brief regarding ICFs would apply equally to SNFs. For this reason, we use the phrase "nursing home" to refer jointly to ICFs and SNFs.

individuals.[9] As a result, many ICFs and SNFs now care for large numbers of patients who are former mental hospital patients or, who, in the absence of alternative care, might have been initially placed in a mental hospital.

In response to the influx of these individuals into nursing homes, the Secretary has decided to ignore statutory language providing Medicaid coverage for SNF and ICF services,[10] and to redefine certain nursing homes that provide

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9/ See, e.g., National Institute of Mental Health, "Deinstitutionalization: An Analytical Review and Sociological Perspective," 1, Series D, No. 4, Publication No. 76-351 (1976).

10/ See 42 U.S.C. §§ 1396d(a)(4)(A), (a)(15).

services to many of these patients as IMDs.[11] As demonstrated below, this response to the deinstitutionalization of the mentally ill directly conflicts with the congressional policy of

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11/ HHS has freely admitted that the basis for its attempts to redefine certain ICFs and SNFs as IMDs is the influx of former mental patients into these nursing homes. See Office of the [HHS] Inspector General, Identification of Institutions for Mental Disease under Title XIX of the Social Security Act, Massachusetts Department of Public Welfare I, Audit Report No. 01-20202 (1981) [hereinafter cited as Audit Report].

In response to this influx, HHS developed the criteria upon which the disallowance in this case is based. HHS Field Staff Information and Instruction Series (FSIIS) FY-76-156 (Sept. 14, 1976); FY-76-97 (May 3, 1976); FY-76-44 (Nov. 7, 1975). See Minnesota v. Heckler, 718 F.2d 852, 862 (8th Cir. 1983).

encouraging appropriate care and treatment of the mentally ill and the development of alternatives to mental hospitals.

The deinstitutionalization movement resulted in part from the growing national awareness in the 1950's of the conditions in state mental hospitals.[12] Concerns about the plight of the patients in these institutions led Congress to establish new national legislation and policy toward the treatment of the mentally ill.[13] Initially, in 1955, Congress passed the Mental Health Study Act. Act of July 28, 1955, c. 417, § 3, 69 Stat. 382, codified at 42 U.S.C. § 242b. This Act established the Joint Commission on Mental Illness and Health, and authorized it to conduct a nationwide study of the human and economic problems of mental illness and to recommend solutions to Congress. In a report that was to become the cornerstone for the deinstitutionalization movement, the Commission recommended: establishment of community-based programs for the

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12/ E.g., Steering Committee on the Chronically Mentally Ill, Toward a National Plan for the Chronically Mentally Ill 1-2, Report to the Secretary (December, 1980).

13/ See Comptroller General of the United States, Returning the Disabled to the Community: Government Needs to Do More, Report to the Congress, Appendix I (list of relevant federal legislation) (1977) [hereinafter cited as Comptroller General's Report].

mentally ill; reduction in the number of institutionalized mentally ill patients; improvements in the care of those who remained in institutions; creation of community-based after-care, intermediate care and rehabilitation services; and expansion of the federal role in sharing with state and local governments the costs of providing mental health care.[14/]

Following this report, Congress enacted in 1963 the Mental Retardation Facilities and Community Mental Health Centers Construction Act, 42 U.S.C.

14/ Joint Commission on Mental Illness and Health, Action for Mental Illness, Report to the Congress (1961), cited in Comptroller General's Report, supra note 13 at 205.

§ 2689 (repealed in 1981), which encouraged the development of community-based services for the mentally ill by authorizing federal funds for the construction of community mental health centers. Two years later, in 1965, Congress provided further federal financial support for the care of the mentally ill when, in enacting the Medicaid program, 42 U.S.C. §§ 1396 et seq., it provided Medicaid reimbursement for inpatient care for the mentally ill in general medical facilities, 42 U.S.C. § 1396d(a)(1), and for IMD services for individuals who are over the age of sixty-five. 42 U.S.C. §§ 1396a(a)(20), (21).[15/] Congress al-

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15/ Congress chose not to include Medicaid reimbursement for IMD services for patients under age sixty-five because it

(footnote continued)

lowed this coverage, however, only on the condition that states continue to develop alternatives to mental hospitals (IMDs) in caring for the mentally ill of

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(footnote continued)

wished to discourage the use of state mental hospitals in treating the mentally ill. See S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in [1965] U.S. Code Cong. and Ad. News 1943, 2084-85. "The residual exclusion of large state institutions for the mentally ill from federal assistance rests on two related principles: states traditionally have assumed the burdens of administering this form of care, and the Federal Government has long distrusted the economic and therapeutic efficiency of large mental institutions." Schweiker v. Wilson, 450 U.S. 221, 242 (1981) (Powell J., dissenting), citing S. Rep. No. 404, supra, reprinted in [1965] U.S. Code Cong. and Ad. News at 2084. See H.R. Rep. No. 694, 88th Cong., 1st Sess. 11, reprinted in [1963] U.S. Code Cong. and Ad. News 1054, 1064. Congress determined, however, that the availability of appropriate alternatives to mental hospitals was particularly a problem for the elderly and, thus, allowed an exception for them.

all ages. 42 U.S.C. § 1396a(a)(20), (21).16/

Congress further extended Medicaid coverage for care of the mentally ill in 1971. Amendments to Title XIX provided for reimbursement of "intermediate care facility services," see 42 U.S.C. § 1396d(a)(15), for "individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is assigned to provide, but who because of their mental or physical condition require care and services . . . which can be made available to them only through institutional

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16/ Minnesota v. Heckler, 718 F. 2d at 864, citing S. Rep. No. 404, reprinted in [1965] U.S. Code Cong. and Ad. News at 2085. See 42 U.S.C. §§ 1396a(a)(20), (21); 42 C.F.R. § 441.106.

facilities." 42 U.S.C. § 1396d(c)(1) (emphasis added). Congress specifically added this coverage to ensure the availability of intermediate care for those who needed it, and who "in the absence of . . . [such care] would require placement in a skilled nursing home or mental hospital."[17/] In providing this coverage, Congress recognized that there were individuals who had mental disabilities but who, nevertheless, did not require placement in traditional psychiatric facilities. Thus, Congress defined an ICF not by the Secretary's standard of whether large numbers of the

17/ Report of the Senate Finance Committee, printed in Statement of Senator Long, 117 Cong. Rec. 44721 (1971).

facility's patients might otherwise have been mental hospital patients, but by the actual nature and degree of care needed by these patients.

Congress also provided a system to ensure that a patient's needs are fully and appropriately met at a particular facility. 42 U.S.C. §§ 1396b(i)(4); 1396a(a)(30), (31); 1395x(k). This system of "independent professional review" or "utilization control review" provides for independent reviews by health-care professionals of a patient's needs and of the appropriateness of placement, both prior to admission in a facility and periodically thereafter. The review examines the feasibility of meeting the patient's needs through alternative services. 42 U.S.C. § 1396a(a)(31); 42

C.F.R. § 456.[18] Congress also established a system of professional review to ensure that when a patient needs services, such as intensive psychiatric services, which a nursing home is not equipped to provide, the patient either is transferred from the nursing home or is not accepted by that facility.[19]

By providing Medicaid coverage for ICF services, Congress intended to encourage the development and use of ICFs as alternatives to state mental

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18/ See Senate Finance Committee Report, supra note 17 (emphasis on the role of the independent professional review team in assuring appropriate placement); Minnesota v. Heckler, 718 F. 2d at 866 n. 27.

19/ See 42 C.F.R. §§ 405.1121(1)(1), 442.306.

hospitals for individuals who might otherwise require psychiatric hospitalization. Congress further ensured the appropriate use of nursing homes through the system of utilization review.

Contrary to the will of Congress, the Secretary now seeks to redefine ICFs as IMDs based on factors relating not to the patients' actual needs, but to the number of a facility's patients who are former or potential mental hospital patients. In so doing, the Secretary contradicts specific congressional intent regarding Medicaid coverage of nursing home services, and general congressional policy toward treatment of the mentally ill. The Secretary also exceeds her authority by ignoring the statutory focus

on the services required by and provided to a patient, and by frustrating the system established by Congress for ensuring appropriate placement and treatment of the mentally ill.

2. The Secretary's Action Improperly Punishes States That Responded To Congressional Directives By Developing And Utilizing Alternatives To Mental Hospitals In Caring for The Mentally Ill.

Relying upon Congressional financial incentives and directives regarding the care of the mentally ill, many states have developed alternative facilities and services to replace mental hospitals.20/ Nearly twenty years ago, while Congress first wrestled with the problems of the mentally ill, the

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20/ Between 1955 and 1980, the resident populations of public mental hospitals

(footnote continued)

Massachusetts General Court enacted the Comprehensive Mental Health and Retardation Services Act of 1966, St. 1966, Ex. Sess., ch. 735, Mass. Gen. Laws Ann. ch. 19, §§ 1 et seq., which established a comprehensive statewide program to deliver mental health services at the community level. Massachusetts subsequently developed a wide variety of community-based services for the mentally ill which now include, in addition to nursing homes and inpatient psychiatric hospitals, outpatient day treatment, twenty-four hour emergency, diagnostic and consultation services, vocational and educational

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(footnote continued)

decreased nationally by about 75%, from 559,000 to 138,000. J. Gudeman and M. Shore, Beyond Deinstitutionalization, 311 New Eng. J. of Med., 832 (1984).

workshops, and various other facilities. These programs, excluding nursing home services, serve over 100,000 individuals each year, of which approximately 92% are treated through community-bassd residential, outpatient, or support services. Only 8% of the individuals were treated through state mental hospitals and inpatient mental health center services.21/

This network of community-based alternatives to institutionalization differs markedly from the stark absence of publicly funded alternative care available prior to 1966. At that time, there existed one community mental health

21/ In fact, by 1981, 90% of former state hospital patients were in alternative settings. J. Gudeman and M. Shore, supra note 20 at 883.

center and a scattering of child guidance clinics. Eleven state mental hospitals housed over 20,000 patients. In fact, current estimates are that state mental hospital populations have decreased from roughly 23,000 in 1960 to the current level of about 2000.22/

Like other states, Massachusetts responded to federal financial incentives, offered primarily through the Medicaid program, to further the development and utilization of nursing homes. The Federal Government has estimated that, nationally, nursing home populations grew an average of 8.1% annually between 1963, the year of the Mental Retardation Facilities and Community Mental Health

22/ J. Gudeman and M. Shore, supra note 20 at 833.

Centers Construction Act,[23] and 1973, with the greatest growth occuring after Medicaid was enacted in 1965.[24] This trend continues today in Massachusetts, which shows an 18% increase in the number of nursing home beds available between 1971 and the present.[25] Thus, Massachusetts statistics show that, as

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23/ General Accounting Office, Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly (Report to the Chairman of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives) (Oct. 21, 1983).

24/ See, e.g., Comptroller General's Report, supra note 13, at 8.

25/ The number of nursing home beds available in Massachusetts increased from 39,512 in December, 1971, to 46,521 in December, 1984.

the state mental hospital populations declined, the Commonwealth developed other forms of care, such as community mental health services and nursing homes.

The Masssachusetts experience exemplifies the nationwide response to congressional encouragement of the development and utilization of nursing homes and other alternatives to mental hospitals. The Secretary now attempts, however, to disallow retroactively the federal share of Medicaid paid to many of these nursing homes. These efforts by the Secretary not only are misguided and contrary to congressional intent; they also unfairly punish states such as Massachusetts which, in a spirit of "cooperative federalism," responded to Congressional directives and Medicaid

program requirements for care of the mentally ill.

CONCLUSION

For the reasons set forth above, the judgment of the Court of Appeals for the Second Circuit should be reversed.

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